STATE OF MICHIGAN

IN THE SUPREME COURT

APPEAL FROM THE MICHIGAN COURT OF APPEALS
(Murray, P.J., and Sawyer and Smolenski, JJ.)

BRUCE B. FEYZ, M.D.,
Plaintiff - Appellee

v

MERCY MEMORIAL HOSPITAL, MEDICAL STAFF OF MERCY MEMORIAL HOSPITAL, RICHARD HILTZ, JAMES MILLER, D.O., JOHN KALENKIEWICZ, M.D., J. MARSHALL NEWBERN, D.O., and ANTHONY SONGCO, M.D.

Defendants - Appellants

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Supreme Court
Case No. 128059

Court of Appeals
Case No. 246259

Monroe County Circuit Court.
Case No. 02-14174-CZ

BRIEF OF
PLAINTIFF-APPELLEE BRUCE B. FEYZ, M.D.

ORAL ARGUMENT REQUESTED

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Plaintiff concurs with Defendants statement of Jurisdiction.

QUESTIONS PRESENTED

WHETHER THE COURT OF APPEALS CORRECTLY ANALYZED THE HISTORICAL UNDERPINNINGS OF THE DOCTRINE OF JUDICIAL NONREVIEW OF HOSPITAL STAFFING DECISIONS, AND PROPERLY INTERPRETED ITS APPLICATION, PERMITTING JUDICIAL REVIEW OF PLAINTIFF'S CIVIL RIGHTS, CONTRACT AND TORT CLAIMS?

Plaintiff asserts the answer is yes.

Defendants assert the answer is no, at least with respect to contract and tort claims.

The Court of Appeals held the answer is yes, with Judge Murray concurring in part and dissenting in part.

WHETHER A DEFENDANT SEEKING PEER REVIEW IMMUNITY PURSUANT TO MCL 331.531 MUST COMPLY WITH ALL STATUTORY REQUIREMENTS, INCLUDING THE REQUIREMENT OF DUE APPOINTMENT AS A MEMBER OF A BONA FIDE PEER REVIEW COMMITTEE, AND WHETHER, IN THIS CASE, ONLY THOSE DEFENDANTS WHO ACTUALLY ARGUED BELOW THAT THEY WERE DULY APPOINTED CAN BE ELIGIBLE FOR PEER REVIEW IMMUNITY?

Plaintiff asserts the answer is yes to both.

Defendants assert the answer is no

The Court of Appeals held the answer is yes.

WHETHER ACTS OF DISCRIMINATION IN VIOLATION OF STATE AND FEDERAL CIVIL RIGHTS STATUTES ARE ACTS WITHIN THE SCOPE OF LEGITIMATE PEER REVIEW, AND WHETHER SUCH ACTS ARE ACTS OF MALICE SUFFICIENT TO DEFEAT PEER REVIEW IMMUNITY.

Plaintiff asserts the answer is no to the first, and yes to the second.

Defendants assert the answer is yes to the first and no to the second.

The Court of Appeals held the answer is no to the first, and yes to the second. Judge Murray concluded yes to the question of scope, and also held the Complaint alleged malice, but on grounds different from the majority.

WHETHER PLAINTIFF'S CIVIL RIGHTS AND TORT CLAIMS REMAIN VIABLE ASSUMING, ARGUENDO, THAT NO ALLEGATION OF MALICE WAS MADE WITH RESPECT TO DEFENDANTS' REFERRAL OF PLAINTIFF TO THE STATE HEALTH PROFESSIONAL RECOVERY PROGRAM?

Plaintiff asserts the answer is yes.

Defendants assert the answer is no.

The Court of Appeals did not consider the question directly, but implicitly held yes.

STATEMENT OF FACTS

Plaintiff's version of the facts appears below. It is first necessary to point out that Defendants' statement of facts mischaracterizes the allegations in the Complaint in several vital areas – attempting to portray Plaintiff as uncooperative, perhaps unstable, and insistent on violating unspecified, or at least undocumented, hospital policies. The unsupported factual averments are not found in the Complaint, and demonstrate again a principal flaw in Defendants' pleadings that was noted by the Court of Appeals. Defendants moved for summary disposition under MCR 2.116(C)(8), not (C)(10), and they simply cannot prevail by repeatedly asserting contested facts and by inserting alleged facts and characterizations not contained in the Complaint.

In particular, Defendants create two areas of potential confusion this Court should be mindful of in reading the statement of facts. First, Defendants often resort to sweeping statements and arguments about immunity or malice with regard to all "Defendants" when such determinations must necessarily be made as to each Defendant separately Second, Defendants repeatedly treat the disciplinary proceedings in 1998 and the proceedings in 2000 as a single incident, when in fact there were different actors involved. Thus, Defendants repeatedly assert that the Medical Staff's Executive Committee placed Plaintiff on probation. While this is accurate with respect to the 2000 probation, it was the Hospital's corporate board of directors, not the Medical Staff Executive Committee, which imposed probation in 1998. The composition of the Medical Staff Executive Committee, and the Medical Staff By-Laws, changed between 1998 and 2000, and Defendant Miller was no longer its chair in 2000. With these above caveats in mind, Plaintiff's statement of facts from his brief on appeal follows:

A. Introduction

Plaintiff Bruce Feyz, M.D. is a member of the medical staff at Defendant Mercy Memorial Hospital in Monroe, Michigan, where he has practiced since 1978. In 1992 Plaintiff took steps to improve care at the hospital by requesting that hospital nurses ask certain questions of his patients during admission to determine whether they were taking their medications in accordance with their prescriptions. Hospital administrators were aware of his efforts.

Years later in the late 1990s, hospital administrators expressed concern over this practice. Plaintiff suspended his instructions to nurses for over a year, and attempted to work with appropriate committees of the hospital's medical staff to address any potential concerns. When it became clear that hospital administration would not act on the issue, Plaintiff resumed writing the instructions.

This litigation arises from the discipline that followed. In order to silence the debate over patient care, Defendants resorted to extraordinary disciplinary action. They placed Plaintiff on probation on two occasions: in late 1998 for over four months, and again in 2000, this time permanently. On each occasion procedural and due process of the medical staff by-laws were ignored, and the disciplinary process was subverted to exert control over Plaintiff and terminate his efforts to improve patient care.

B. The Parties

Plaintiff is a physician licensed by the State of Michigan. He has continuously held staff privileges at Mercy Memorial Hospital. During his tenure at Mercy no patient has ever asserted a malpractice claim against Plaintiff. No patient of his has ever complained about him to a licensing agency, and his license to practice medicine has never been suspended or revoked. Other than the incidents giving rise to this action, his career is unblemished.

Mercy Memorial Hospital is a private hospital, the only such facility in Monroe. Defendant Richard Hiltz was its president at times relevant to this action. Physicians and other health care providers at the Hospital are organized into a medical staff (the "Medical Staff") which is also a named defendant[1]. The Medical Staff is organized into various committees, and is governed by its own by-laws[2].

Defendant James Miller, D.O., was Chief of Staff of the Hospital and Chairman of the Medical Staff's Executive Committee at the time of the 1998 disciplinary action. The remaining three individual defendants are members of the Medical Staff and were members of an Ad Hoc Committee appointed by Miller to recommend discipline against Plaintiff in 1998.

C. The Patient Care Issue (Complaint ¶¶ 17-20, Apx. 35-36a)

This Court is not asked to determine the answer to any medical question. Plaintiff does not seek injunctive relief ordering that he be permitted to give any particular instruction to Hospital nurses. However, the Court's inquiry will benefit if guided by an understanding of the patient care issue.

Recent years have seen an increase in the number of medications prescribed to patients, especially the elderly. Increasingly, patients are prescribed multiple medications, and increasingly patients do not take these medications in accordance with their doctor's instructions.

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[1] At the Circuit Court, neither party briefed the issue of whether the Hospital and the Medical Staff constitute separate legal entities. They were named separately in the complaint should a determination be made that they are separate, and that one is not liable for the actions of the other. The same is true of their respective officers and members (although each is named in both an individual and official capacity, see Complaint ¶¶ 4-8, Apx. 34a). For certain important purposes, the two basic types of Defendants (hospital vs. medical staff) are discussed separately, as are the individual roles of the individual Defendants. In other instances, both for convenience and as alternative pleading, the "Defendants" are discussed as a single group, though it may be that not all Defendants took part in every action complained of.

[2] Unless expressly stated otherwise, all references in this brief to "by-laws" mean the Medical Staff By-Laws, and not the corporate by-laws of the Hospital. Likewise, all references to committees mean committees of the Medical Staff, and not committees of the Hospital's Board of Trustees.

Deviations from the prescribed medication routines are referred to as non-compliance in the medical literature.

There are numerous reasons for non-compliance: inability to pay, patient misunderstanding due to illiteracy or language barriers, lack of coordination among multiple physicians, and patients simply choosing to take medications in doses and frequencies other than prescribed. Non-compliance presents obvious threats to patients. A physician must take into account what medications are actually being taken. Failure to do so can result in serious errors.

For decades, hospital nurses have performed patient intake assessments; including asking patients about their medications. Accurately documenting medication usage has become more difficult. Often a nurse must rely on a list of prescriptions provided by a family member or an examination of a "brown bag" of medications. Prescription lists and or the labels on vials provide only the *prescribed* dosages and frequencies. If the patient is non-compliant, the *actual* dose and frequency may vary materially. Non-compliance can create or mask symptoms or side effects which may go untreated if the physician simply assumes the patient is taking the prescribed dose.

D. Plaintiff's Approach to Patient Non-Compliance

Beginning in 1992 Plaintiff attempted to reduce the risks of non-compliance by having nurses ask patients how they are *actually* taking their medicines and recording their answers. Over time he standardized the orders and inserted them as four standing orders to be followed for all of his patients. These orders are referred to as "Orders A-D."

Orders A-D instruct the nurse to do the following as part of the patient intake process:

A. Have the family bring in home medications.

B. Ask the patient (if alert) if the containers belong to the medications. If not, send the container(s) to the pharmacy for identification.

C. Ask the patient to look at his/her medications inside the container and tell how he/she has been taking them at home.

D. List the dose and frequency of medications taken on the nursing assessment form as the patient is actually taking them at home.

Complaint, ¶¶ 21-22, Apx. 37a.

E. Defendants' Response: 1993-1995 (Complaint ¶¶ 25-29, Apx. 38-39a)

Nurses followed the orders. In early 1993, the head nurse informed Plaintiff that hospital administrators had removed Orders A-D from his standing orders. Plaintiff met with a hospital administrator, explained the reasons for Orders A-D and asked that they be continued, either as standard hospital policy or as Plaintiff's standing orders. The administrator responded that the nurses wouldn't like it, but that she would try.

For months Plaintiff attempted to follow-up with Hospital administrators, who were reluctant to discuss the issue. Later in 1993 Plaintiff resumed his initial practice of writing Orders A-D in each patient's chart (rather than as a standing orders for all his patients).

Most nurses followed the orders, but some did not. As a general practice, if the orders were not followed and Plaintiff identified a risk of medication error as a result, he instructed that an incident report be prepared for that patient. In some instances Plaintiff referred the case to the Quality Assurance Committee ("QAC") and provided a copy of the referral to Hiltz. By so doing Plaintiff kept hospital administrators aware of his practice.

In 1995 Plaintiff requested a meeting with Hospital administrators because his orders were not consistently being followed. At a meeting attended by Hiltz, the Director of Nursing and some nurses, Plaintiff again explained his reason for Orders A-D. Neither Hiltz nor anyone else asked Plaintiff to stop writing Orders A-D (as might be expected if they contravened Hospital policy or asked the nurses to violate their licensing requirements).

F. Defendants' Subsequent Response: 1996-98 (Complaint ¶¶ 30-38, Apx. 39-40a)

In a November 1996 meeting of the Utilization Committee, Hospital administrators expressed concern over an "unnamed physician" who was writing orders for incident reports and referrals to the QAC (with copies to Hiltz)[3]. Plaintiff was a member of the Utilization Committee and disclosed to the committee that he was the physician in question.

The concerns expressed at the Utilization Committee were not with Orders A-D *per se*, or how those orders affected nurses or patient care. Rather, the expressed concern was that documents might someday fall into the hands of a plaintiff's lawyer. The Utilization Committee suggested that Plaintiff refrain from writing the orders and bring the issue to committee. Plaintiff complied and began working in good faith within the Medical Staff committee structure, just as he had previously attempted with Hospital administrators. This was the first time that anyone had asked Plaintiff to refrain from writing the orders.

Plaintiff refrained from writing the orders from November 1996 through early 1998. Despite Plaintiff's good faith efforts in committee, Hospital administrators refused to address the issue. In April 1998 Plaintiff expressed his concerns to Hiltz in writing. Because senior hospital management would not address the issue, in April 1998 Plaintiff resumed writing Orders A-D in the individual charts of his patients.

In May 1998 Plaintiff learned that Hiltz had instructed nurses not to follow Orders A-D. Plaintiff received no prior notice that his instructions to nurses had been contravened. Plaintiff believed that if a non-physician hospital administrator was giving patient care orders, those

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[3] As alleged in the complaint at ¶28, it appears that in late 1995 or early 1996 the Executive Committee, at the Hospital's urging, passed a motion requiring a physician who had been writing "inappropriate" orders to appear before the Executive Committee. It may be that Plaintiff was the physician in question, but if so the motion was not acted on as Plaintiff was never asked to appear.

orders should be documented in the patient's chart as required by law. He instructed nurses to include administrations patient care orders in patient charts.

Spring 1998 marked an escalation of the debate over patient care standards at the Hospital. Plaintiff was determined to move resolution of the issue forward and to reduce the chances of medication errors. Hospital administration was determined not to resolve the issue – apparently satisfied to let the matter rest so long as Plaintiff voluntarily stopped writing Orders A-D.

When Plaintiff resumed writing Orders A-D, the Hospital responded with disciplinary action. Oddly, at the same time discipline was being imposed, other Hospital administrators worked with Plaintiff to develop alternative means to meet Plaintiff's patient care issues by utilizing a pharmacy consult procedure. It effect, one arm of the Hospital was disciplining Plaintiff for raising patient care concerns, while another arm was working to meet those concerns.

G. The 1998 Disciplinary Action (Complaint ¶¶ 48-70, Apx. 343-45a)

Plaintiff was disciplined in September 1998. The allegations regarding this incident appear at paragraphs 48-70 of the Complaint. The disciplinary action began to unfold in May 1998, the day before Plaintiff was scheduled to appear before the Executive Committee to discuss their handling of an unrelated patient charting issue that had been resolved in Plaintiff's favor[4].

The day before Plaintiff was to appear before the Executive Committee, he received notice that the proceedings would now include a disciplinary charge on the issue of Orders A-D.

[4] The patient charting issue, though unrelated to the noncompliance issue, is relevant in that it shows Defendants' predisposition to resort to use discipline to shape debate over hospital policies. It also indicates Hiltz's potential motive in resorting to discipline over Orders A-D. The patient charting issue is alleged at paragraphs 39-47 of the complaint and described in greater detail, *infra*.

Adding a new disciplinary charge the day before the meeting violated the medical staff by-laws. They provide for advance notice, for referrals of any such issues through appropriate Medical Staff committees, and other important procedural safeguards. No action was taken on the new charge when the Executive Committee met.

Two months later Hiltz requested that Miller commence disciplinary action against Plaintiff. Hiltz may have mentioned charges other than Orders A-D. However, when Miller informed Plaintiff he identified only one issue, Orders A-D. Miller withheld notice of any other alleged charges. Complaint at ¶52-53.

Rather than refer the matter to appropriate committees, Miller formed an *ad hoc* disciplinary committee. The committee consisted of Defendants Kalenkiewicz, Newbern and Songco. The purpose of this committee was purely disciplinary. The committee never met with Plaintiff or requested a meeting. Throughout the committee's deliberations, Plaintiff remained without notice as to any issues other than Orders A-D.

The committee issued a report in late September. The Executive Committee took action, purportedly on the findings of the ad hoc disciplinary committee. For reasons that remain unclear, the Executive Committee voted to refer Plaintiff the Health Professional Recovery Program – the state's program for impaired physicians. No Defendant held a good faith belief that Plaintiff was or might be impaired. He wasn't, as the mandatory psychiatric examination that followed proved[5].

On the same day the Executive Committee voted, the Hospital Board of Trustees placed Plaintiff on indefinite probation action after hearing a presentation by Hiltz and Miller.

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[5] The HPRP referral set in motion a procedure that mandated a psychiatric examination by the State. See MCL 333.16233. Plaintiff contends this referral/examination violates federal and state disability discrimination statutes, and forms one of the bases for the discrimination counts in the complaint.

This entire disciplinary cycle occurred without input from Plaintiff. He was not notified of the charges or given an opportunity to be heard. The *ad hoc* disciplinary committee reached is alleged conclusions without contacting Plaintiff. No emergency mandated this approach. Plaintiff was not seen as a threat to patients or himself. Throughout these events Plaintiff retained Hospital privileges and continued to treat patients.

Near the time of the 1998 discipline, a Hospital Vice-President proposed that Plaintiff utilize a pharmacy consult procedure instead of writing Orders A-D. Though cumbersome, this approach met Plaintiff's patient care concerns, and he agreed. His agreement came prior to the Executive Committee action, but Hiltz and Miller intentionally withheld that fact from the Ad Hoc Committee, the Executive Committee and the Board of Trustees. Complaint at ¶¶63-65, Apx. 45a-1.

Having achieved their objective of silencing Plaintiff, the Defendants avoided further proceedings required under the by-laws. When Plaintiff attempted to secure a fair hearing, he was refused. Rather than permit Plaintiff an opportunity to contest what had unfolded, Defendants simply lifted the probation on February 1, 1999. Plaintiff never received an opportunity to rebut the charges against him. Complaint at ¶¶66-70.

H. Subsequent Events: 1998 – 2000 (Complaint ¶¶ 71-81, Apx. 45-47a)

Plaintiff made use of the pharmacy consult. Instead of nurses asking the questions contained in Orders A-D, a Hospital pharmacist asked them[6]. The system worked.

This did not end Plaintiff's efforts to seek redress. When it became clear that his efforts to obtain redress under the by-laws were futile, Plaintiff retained counsel and threatened to assert

[6] If this strikes the Court as cumbersome, it should. It appears the Hospital's motivation was to avoid a scenario where nurses were performing a higher level of care for one doctor (Plaintiff) but not for other physicians (who had not requested the intake questions in Orders A-D). The pharmacy consults may have been intended to insulate the Hospital from subsequent charges that it should have adopted the nursing practice for all patients.

claims under federal and state anti-discrimination laws in June 1999. The issue still was not resolved.

Shortly thereafter, Defendants began dismantling the pharmacy consult procedures. Plaintiff had been instructed to use the pharmacy consult for all his patients, including those admitted after hours and on weekends. He had done so. In December 1999 a minority of the Executive Committee concurred in a request by Hospital Administration to limit availability of pharmacy consults to 7:00 a.m. to 10:00 p.m. daily. The concurrence occurred at an Executive Committee meeting without quorum or a formal vote.

Neither the Executive Committee nor Hospital administration informed Plaintiff (or the medical staff at large) that pharmacy consults were being curtailed. Plaintiff learned of the change only after a nurse informed him that an after-hours pharmacy consult could not be obtained.

Plaintiff was concerned about this limitation, and expressed his concerns through appropriate mechanisms: in writing to Hiltz and to the Pharmacy and Therapeutics Committee. The committee heard Plaintiff's concerns in late March 2000, but deferred action pending Hiltz's response to Plaintiff. No response came.

In late May 2000, Defendants further limited the availability of pharmacy consults, removing them on weekends, holidays and evenings. This time the reduction was effected without notice to or action by any Medical Staff committee. Plaintiff again wrote Hiltz suggesting alternative to assure patient care. Again Hiltz did not respond.

The Complaint alleges that the Hospital and Hiltz were deliberately manipulating the pharmacy consult process. The were attempting to provoke a reaction that could serve as pretext to retaliate against Plaintiff for threatening to assert his civil right. Complaint at ¶89, Apx. 48a..

It worked. Faced with limited availability of pharmacy consults, and silence from the Hospital and Hiltz, Plaintiff resumed writing Orders A-D for patients admitted after hours.

The Hospital, Hiltz in particular, insisted that the Executive Committee commence disciplinary action, and attempted to secure summary suspension of Plaintiff's medical staff privileges.

No longer headed by Miller, and aware that Plaintiff had retained counsel after the 1998 incident, the Executive Committee was not as quick to act this time. It refused the request for summary suspension, and instead requested a legal opinion from outside counsel, other than the Hospital's counsel, as to whether Plaintiff's orders were legal, and whether the Hospital's refusal to permit nurses to follow the orders was legal. At least some members of the Executive Committee questioned whether Plaintiff was doing anything inappropriate.

The Hospital's outside counsel (current counsel in this action), appeared before the Executive Committee on August 14, 2000. The minutes of that meeting reveal that the requested opinion was not provided. Rather, counsel advised the Executive Committee that if they were sued such suits are usually dismissed, that statutes provide immunity from damages, that liability for Executive Committee members was not a big risk, and that, at most, members could be involved in depositions.

Moreover, counsel framed the advice in terms of comparative risk of suit by a patient. There was no basis for this analysis, patient care had not been adversely affected, and counsel made no effort to ascertain from Plaintiff whether any delay or other adverse affect had occurred. Regardless, the committee commenced disciplinary proceedings.

All parties involved were aware that Plaintiff was represented by counsel. In a letter dated August 15, 2000, Plaintiff was instructed to appear before the Executive Committee, *without counsel*, on August 29, 2000. It is unclear who added the requirement that Plaintiff be

denied counsel[7]. The minutes of the Executive Committee meeting reveal no such restriction[8]. When Plaintiff attended that meeting, he was shocked to discover that the Defendants were represented not only by the Hospital's in-house counsel but that outside counsel was in attendance as well.

For writing Orders A-D, Plaintiff was placed on permanent and indefinite probation, where he remains today. He is no longer permitted to use the pharmacy consult at all, even during daytime hours, though that privilege is available to other staff members. If Plaintiff ever writes Orders A-D he is subject to summary suspension or revocation of his Hospital privileges. Because of the Hospital's economic clout as the sole facility in Monroe, Plaintiff dare not raise the issue again.

The procedures used by the Defendants in 2000 directly contradicted by-law provisions for discipline, which had recently been amended. Section 7.1-2 of the By-Laws had been amended to provide that all requests for corrective action (discipline) be submitted not to the Executive Committee but rather to the Chief of Service (i.e., department head) and Chief of Staff for resolution *within the department*. Only if satisfactory resolution is not obtained within the department is the matter referred to the Executive Committee.

Defendants circumvented the by-laws and forced Plaintiff into the flawed Executive Committee procedures outlined above. In so doing, Plaintiff was deprived of the opportunity to resolve the matter within his department, without the enormous influence of Hospital administration and their legal representatives.

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[7] The statute of limitation had not run on any of the threatened civil rights actions. It was dubious, at best, to require an adverse party with known representation to appear without counsel at a disciplinary hearing touching on those issues, when the Hospital was represented by counsel at those proceedings.

[8] The minutes do reveal that Plaintiff would not be permitted to record the meeting, and it appears no record was made. Absent a record, Plaintiff relied solely on a written submission to the Executive Committee.

Plaintiff acquiesced in the probation – he had no choice. Defendants were not quite finished with their retaliation. After the 2000 disciplinary action, the Hospital refused to renew a contract with Plaintiff for EKG interpretive services. Plaintiff had provided such services at the Hospital for years. Defendants acknowledge that the decision not to renew was directly related to the retaliatory probation in 2000. In their Brief below Defendants averred that the contract was not renewed because Plaintiff, as a physician on probation, was not eligible for contract renewal. Defendants' Trial Court Brief pp.5-6, Apx. 99-100a.

As of today, Plaintiff is on permanent probation. He has never been provided the due process rights he is entitled to under the by-laws. His patients are not screened on admission to the Hospital for potential non-compliance unless he does so personally, something he cannot do 24 hours a day.

SUMMARY OF ARGUMENT

Michigan's peer review statutes afford meaningful protection to legitimate peer review activities of health care providers. These protections include civil and criminal immunity, confidentiality, and evidentiary privilege, and other protections. However, each is strictly conditioned on compliance with statutory requirements. None is available merely by declaration of the party asserting protection.

This Court has established a framework for reviewing disputed claims of privilege and immunity. Where, as here, a Plaintiff alleges facts challenging the status of an alleged review entity, whether is has acted within a proper scope, or whether is has acted with malice, the claims should not be dismissed on a motion brought under MCR 2.116(C)(8).

The Court of Appeals correctly held Defendants were not entitled to dismissal on the grounds of peer review immunity. Discriminatory acts are never entitled to peer review

immunity because they are outside the proper scope of peer review and because the are acts of malice which, under Michigan's immunity statute, removes immunity.

Under the immunity statute, only duly appointed peer review committees are entitled to immunity. Defendants only argued due appointment with respect to three individual defendants who served on an Ad Hoc Committee. The Court of Appeals correctly held all other Defendants have waived their immunity claims. Even if not waived, the Complaint alleges facts sufficient to find the Defendants were not duly appointed.

Plaintiff alleges malice as to all Defendants, under any of several definitions of malice used by the Court of Appeals and under the ill-will standard advanced by Defendants at the trial court. Defendants are barred from asserting a different standard now.

After considering peer review immunity, the Court of Appeals correctly and carefully analyzed Michigan's doctrine of judicial nonreview of medical staffing decisions, and concluded significant jurisprudential drift had occurred, resulting in an overbroad application of the doctrine that moved well beyond its limited purpose. This holding should be affirmed, and Michigan courts should consider medical staffing claims based upon contract and tort. They already do so for antitrust and discrimination claims, as do Federal courts.

Finally, Defendants are entitled to no immunity for their bad faith referral of Plaintiff to the Health Professional Recovery Program. The Complaint sufficiently alleges there was no basis of belief among Defendants that circumstances warranted this referral, and is was made only as a tool to coerce Plaintiff.

STANDARD OF REVIEW

Plaintiff concurs that a grant or denial of summary disposition pursuant to MCR 2.116(C)(8) is reviewed *de novo*. Wickens v Oakwod Healthcare System, 465 Mich 53 (2001).

ARGUMENT

I

MICHIGAN'S PEER REVIEW STATUTES PROTECT ONLY *BONA FIDE* REVIEW ENTITIES ENGAGED IN LEGITIMATE PEER REVIEW

The Court of Appeals correctly held Defendants were not engaged in protected peer review. Throughout their briefs, here and below, Defendants nakedly assert that a given action was "clearly peer review" or that all defendants are "entitled to peer review immunity." They do so without discussing how the legislature has defined peer review or the strict limits to immunity enacted by the legislature. Defendants' favored approach is to allow the party grasping for immunity to self-define peer review and then claim immunity by declaration. The legislature did not place civil and criminal immunity on such a slippery slope. This Court should consider the entire statutory peer review framework to interpret what is, and is not, peer review and when immunity is available.

A. Overview of Michigan Peer Review Statutes

Michigan's peer review statutes mandate review, protect the confidentiality of specified communications, and provide limited immunity if statutory conditions are met. Peer review provisions are codified in several chapters and articles, and must be read in conjunction with each other.

The immunity provisions appear at MCL 331.551 (the "immunity statute"). The immunity statute: 1) authorizes providing information to a review entity, 2) defines "review entity," 3) grants immunity for certain acts, and 4) removes immunity for malicious acts. It states:

> (1) A person, organization, or entity may provide to a review entity information or data relating to the physical or psychological condition of a person, the necessity, appropriateness, or quality of health care rendered to a person, or

the qualifications, competence, or performance of a health care provider.

(2) As used in this section, "review entity" means 1 of the following:
(a) A duly appointed peer review committee of 1 of the following: [various health care entities, including hospitals, discussed *infra*].

(3) A person, organization, or entity is not civilly or criminally liable:
(a) For providing information or data pursuant to subsection (1).
(b) For an act or communication within its scope as a review entity.
(c) For releasing or publishing a record of the proceedings, or of the reports, findings, or conclusions of a review entity, subject to [MCL 331.532] and [MCL 331.533].

(4) The immunity from liability provided under subsection (3) does not apply to a person, organization, or entity that acts with malice.

MCL 331.531

Immunity is an affirmative defense, not an entitlement. A party (*each* party) must satisfy *each* statutory requirement. The party seeking immunity must prove:

1. That the entity involved is in fact a "peer review entity" (which, in the case of hospitals, includes finding the alleged review entity was duly appointed).

2. That information provided falls within the immunity statute's protection.

3. For a review entity, that the act or communication complained of was within its scope as a review entity.

4. For immunity vis-à-vis publication of peer review communications, that the purpose was permitted under MCL 331.532 or 331.533.

Failure to satisfy any one of these requirements defeats immunity. Only if immunity is otherwise established does the question of malice arise. Malicious actions receive no immunity.

1. Defining Peer Review

Immunity is available only with respect to a "review entity" and then only for actions "within its scope as a review entity." MCL 331.551(2) contains a multi-part definition of review entity. The Court of Appeals correctly utilized the following definition for hospitals:

> (2) As used in this section, "review entity" means 1 of the following:
>
> (a) A duly appointed peer review committee of 1 of the following: ...
>
> (iii) A health facility or agency licensed under article 17 of the public health code, 1978 PA 368, MCL 333.20101 to 333.22260.

Opinion p.3; Apx.12a.

The immunity statute does not define "peer review committee" or, for that matter "peer review." At first glance, the definition of "review entity" appears circular. Read in context, however, the immunity statute provides the appropriate frame of reference for determining what constitutes a peer review committee and its appropriate scope.

It is critical to realize that the immunity statute applies to several types of entities and organizations. Some are private and some public, some operate under state law, others federal. Although each can be a "review entity," each has its own mandate and purpose. Enacting a single definition of "peer review" or defining a single "scope of peer review" for all these diverse entities would be difficult, if not impossible. The legislature chose a different path.

In its entirety, the immunity statute defines "review entity" as follows:

> (2) As used in this section, "review entity" means 1 of the following:
>
> (a) A duly appointed peer review committee of 1 of the following:
>
> (i) The state.
> (ii) A state or county association of health care professionals.
> (iii) A health facility or agency licensed under article 17 of the public health code, 1978 PA 368, MCL 333.20101 to 333.22260.
> (iv) A health care association.

(v) A health care network, a health care organization, or a health care delivery system composed of health professionals licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838, or composed of health facilities licensed under article 17 of the public health code, 1978 PA 368, MCL 333.20101 to 333.22260, or both.
(vi) A health plan qualified under the program for medical assistance administered by the department of community health under the social welfare act, 1939 PA 280, MCL 400.1 to 400.119b.

(b) A professional standards review organization qualified under federal or state law.

(c) A foundation or organization acting pursuant to the approval of a state or county association of health care professionals.

(d) A state department or agency whose jurisdiction encompasses the information described in subsection (1).

(e) An organization established by a state association of hospitals or physicians, or both, that collects and verifies the authenticity of documents and other data concerning the qualifications, competence, or performance of licensed health care professionals and that acts as a health facility's agent pursuant to the health care quality improvement act of 1986, title IV of Public Law 99-660, 42 USC 11101 to 11152.

(f) A professional corporation, limited liability partnership, or partnership consisting of 10 or more allopathic physicians, osteopathic physicians, or podiatric physicians and surgeons licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838, who regularly practice peer review consistent with the requirements of article 17 of the public health code, 1978 PA 368, MCL 333.20101 to 333.22260.

(g) An organization established by a state association of pharmacists, that collects and verifies the authenticity of documents and other data concerning the qualifications, competence, or performance of licensed pharmacists and pharmacies.

MCL 331.551(2).

The peer review mandate of each of these diverse groups is best understood by the source of its peer review responsibilities. For hospitals, the legislature defined review entity by referencing Article 17 of the public health code, MCL 333.20101 to 333.22260. These provisions illuminate the meaning of peer review, who may conduct it, and its limitations.

2. Article 17 Defines the Purpose and Limits of Peer Review

MCL 333.21513(d) provides the statutory mandate that hospitals conduct peer review:

> The owner, operator, and governing body of a hospital licensed under this article:
> ...
>
> (d) Shall assure that physicians and dentists admitted to practice in the hospital are organized into a medical staff to enable an effective review of the professional practices in the hospital for the purpose of reducing morbidity and mortality and improving the care provided in the hospital for patients. The review shall include the quality and necessity of the care provided and the preventability of complications and deaths occurring in the hospital.

Id. (emphasis added).

Thus, only the physicians and dentists admitted to practice at a hospital, not its administrators and governing body, are to be organized into a medical staff to conduct peer review. That organizational structure must be designed to allow for *effective* review, and that review must be conducted within the statute's mandated scope: for the purpose of reducing morbidity and mortality and improving the care provided in the hospital for patients. For actions outside this scope, participants receive no immunity.

Like the immunity statute, provisions concerning confidentiality reference MCL 333.21513. For example, MCL 333.21515 states:

> The records, data, and knowledge collected for or by individuals or committees **assigned a review function described in this article** are confidential and shall be used only for the purposes provided in this article, shall not be public records, and shall not be available for court subpoena.

Id. (emphasis added).

Like immunity, confidentiality attaches only with respect to review functions described in Article 17. That description is set forth in MCL 333.21513. Whether a party is seeking immunity or asserting a privilege, the underlying activity must, in fact, be protected peer review. The statute, not the party seeking immunity, provides the definitional framework.

B. Existing Michigan Case Law Provides the Methodology for Evaluating Disputed Claims of Peer Review Privilege and Immunity.

Determining whether an activity is protected peer review, and the procedures for adjudicating disputed peer review claims, are not questions of first impression. In Marchand v. Henry Ford Hospital, 398 Mich. 163 (1976) this Court affirmed the trial court's order that certain medical information be produced over defendant's claim of privilege under former MCL § 331.422[9]. The plaintiffs in that medical malpractice case sought to discover alleged peer review information. The trial court conducted an evidentiary hearing and found that the documents in question (an investigation and research entered into by a physician) was not data or knowledge which was obtained through the review function contemplated by the statute. Accordingly, the trial court ordered discovery, and this Court affirmed that order.

Likewise, in Monty v. Warren Hospital Corporation, 422 Mich. 138 (1985), plaintiff sought production of certain documents, and challenged defendant hospital's assertion that the peer review privilege protected them. In response to plaintiff's motion to compel, the trial court ordered an examination *in open court* of each document in order to determine if the privilege applied. The Court of Appeals denied interlocutory review, but this Court granted leave and affirmed the trial court's approach that each document be examined, but disapproved of an open court review, which might destroy confidentiality of a document later determined to be privileged.

The Monty court stated:

> In determining whether any of the information requested is protected by the statutory privilege, the trial court should bear in mind that mere submission of information to a peer review committee does not satisfy the collection requirement so as to bring the information within the protection of the statute.

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[9] All records, data and knowledge collected for or by individuals or committees assigned this review function are confidential and shall be used only for the purposes provided in this act, shall not be public records and shall not be available for court subpoena.

> *Marchand, supra, 168.* Also, in deciding whether a particular committee was assigned a review function so that information it collected is protected, the court may wish to consider the hospital's bylaws and internal regulations, and whether the committee's function is one of current patient care or retrospective review. Compare *Davidson v Light, 79 FRD 137* (D Colo, 1978), with *Bredice v Doctors Hospital, Inc, 50 FRD 249* (D DC, 1970), *aff'd without opinion 156 U.S. App DC 199; 479 F2d 920 (1973).* See *Coburn v Seda, 101 Wash 2d 270, 277; 677 P2d 173 (1984).*
>
> 422 Mich. at 146-47.

Under Marchand and Monty, courts confronting disputed claims of peer review privilege (or, as here, immunity) must evaluate the facts surrounding each communication or act. A defendant asserting privilege or seeking immunity cannot prevail merely by nakedly asserting that a communication or action was "peer review." The defendant must satisfy the statutory requirements.

In Davis v. O'Brien, 152 Mich. App. 495 (1986) the court considered claims of peer review privilege regarding production of documents. Following Monty, *supra*, the Davis court noted the need for an evidentiary hearing. It focused on the nature of the activities for which peer review privilege was asserted, and held:

> The bylaws of the hospital are, for the most part, irrelevant on the issue of the quality of care rendered plaintiffs' decedent in defendant hospital. However, the bylaws are relevant insofar as they set forth the purpose of the review of members of the hospital staff. **If the bylaws provide that the purpose of the review function is to mete out discipline to physicians providing inadequate health care, then that part of the review conducted by the reviewing entity is not protected by the statutory privilege found in § 21215** (sic)[10]**.**
>
> 152 Mich. App. at 506 (emphasis added).

Davis makes clear that disciplinary activities are not protected peer review. Peer review must entail retrospective review to improve patient care.

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[10] The citation here to § 21215 is believed to be typographical error. No such section exists, and earlier in the case the Davis court cites to MCL §333.21515 as one statutory source of the peer review privilege.

Defendants argue the privilege statutes and cases mandate reinstatement of the nonreviewability doctrine. However, each of the privilege cases cited by Defendants stand for no more than the proposition from Monty, Marchard and Davis – that a factual inquiry specific to each case is required to determine which communications, if any, are entitled to privilege.

A party who challenges a claim of peer review privilege or confidentiality is entitled, at a minimum, to an *in camera* evaluation of the documents and facts which allegedly give rise to privilege and a hearing to determine which parties, if any, are entitled to immunity. When a complaint contains allegations sufficient to defeat a claim of immunity, dismissal under MCR 2.116(C)(8) is inappropriate.

C. The Federal Peer Review Scheme

The federal peer review provisions are set forth in the Health Care Quality Improvement Act. 42 USC § 42111 et seq. Immunity is provided under 42 USC §11111(a)(1), but is limited to immunity for money damages. There is no immunity from suit and equitable relief is always available. Like Michigan, the federal scheme requires that peer review be conducted with a purpose. The following must be true to obtain peer review immunity:

> (a) In general. For purposes of the protection set forth in section 411(a) [*42 USC §11111*(a)], a professional review action must be taken--
> (1) in the reasonable belief that the action was in the furtherance of quality health care,
> (2) after a reasonable effort to obtain the facts of the matter,
> (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3). A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 411(a) unless the presumption is rebutted by a preponderance of the evidence.

42 USC §11112(a).

The HCQIA provides a safe harbor whereby a health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) above if numerous vital due process requirements are satisfied. *See* 42 USC §11112(b), Apx. 142a. Those requirements clearly were not met in this case.

The HCQIA is relevant for several reasons. Most notably, issues of immunity and privilege arise under both the federal and state statutes. Many of the interpretations Defendants urge on this Court conflict with the federal statute. The statutes are different, and this Court will interpret Michigan's statutes as they are written. But if federal law denies immunity or privilege under the same facts, then the protective interpretations urged by Defendants become illusory. If an aggrieved physician can simply proceed in Federal court, any alleged chilling effect on peer review has already occurred.

II

NONE OF THE DEFENDANTS IS ENTITLED TO SUMMARY DISPOSITION ON THE BASIS OF PEER REVIEW IMMUNITY

A. Discrimination is Beyond the Scope of a Peer Review Entity.

The Court of Appeals held, "It is not within the scope of a peer review entity to violate someone's civil rights." Opinion p.3, Apx. 12a. Judge Murray dissented from this holding on the ground that the majority looked at the outcome (liability under the civil rights laws) rather than scope, which he defined as the "range of operation" of a review entity. Dissent p.2, Apx. 26a.

The majority ruled correctly. With respect, Judge Murray missed the import of the majority ruling. Discrimination is not outside the scope of peer review because the civil rights statutes impose liability. Rather, discrimination is outside the scope of peer review because it involves evaluating professional practices and patient care based on the *care provider's* race, gender, or similar characteristic. Such invidious bias never accomplishes the statutory mandate

of peer review - reducing morbidity and mortality and improving the care provided in the hospital for patients.

The flaw in Judge Murray's reasoning becomes apparent if one were to assume that all civil rights statutes were repealed retroactively. Defendants would then face no liability under the civil rights statutes, yet discrimination would still fall outside the scope of peer review. Basing peer review on the race or gender of the physician still would not reduce morbidity or mortality or improve patient care. It would only advance discriminatory *animus* to the detriment, not improvement, of health care. There are several labels one could apply to such conduct – "peer review" is not among them.

Defendants protest that a *per se* rule will permit disparate impact discrimination claims to proceed, creating horrendous burdens on the peer review process[11]. As currently plead, this case is not a disparate impact case[12]. Even if it were, Defendants' fears are both illusory and ill founded. The HCQIA removes immunity for all federal and state civil rights claims, including disparate impact claims. 42 USC §11111(a)(1)(D). Aggrieved physicians can *already* bring disparate impact claims in federal court. Peer reviewers and those providing information to peer review entities already factor this potential liability into their actions, presumably designing peer review processes that do not have disparate discriminatory impact.

B. None of the Defendants was Duly Appointed to a Peer Review Committee

As noted *supra*, for hospitals the immunity statute defines "review entity" as a duly appointed peer review committee. MCL 331.531 (emphasis added). The legislature did not

[11] Defendants do not expressly argue that intentional discrimination or retaliation is entitled to immunity, although this is the outcome if the defamation standard for malice is adopted as Defendants urge. See "Discrimination is an Act of Malice" *infra*.

[12] At the Court of Appeals Plaintiff argued that intentional discrimination and retaliation are beyond the scope of peer review. Plaintiff's Appeal Brief p.36, Apx.53b.

extend criminal and civil immunity to anyone who chooses it. Only those individuals who are duly appointed to a bona fide peer review committee are eligible for immunity.

1. Defendants Waived Their Immunity Defense by Failing to Present Arguments Regarding Due Appointment

The Court of Appeals correctly held that Defendants failed to argue due appointment for any Defendants other than the individual members of the Ad Hoc Committee. Immunity attaches to a party, not to conduct. Immunity for one party does not guaranty immunity for all, and it is incumbent upon each party seeking immunity to demonstrate eligibility.

In this action the Hospital, the Medical Staff, and each of the five individual Defendants must show due appointment. Of the five individuals, only three served on the Ad Hoc Committee (Drs. Kalenikiewicz, Newbern and Songco). Dr. Miller was chairman of the Medical Staff Executive Committee at the time of the 1998 proceedings, but did not serve on the Ad Hoc Committee. Mr. Hiltz, a hospital administrator, is not a physician, not a member of the Medical Staff, and did not serve on the Ad Hoc Committee.

An examination of what Defendants actually argued below confirms that the Court of Appeals ruled correctly. At the trial court Defendants' peer review argument consisted of the text of the statute and three conclusory paragraphs. Brief in Support, pp. 8-10, Apx. 102-104a. Defendants offered no discussion of the "due appointment" requirement, and no analysis of the Medical Staff By-Laws or any other governance documents to show due appointment or that the committees involved were assigned peer review functions. They simply asserted that peer review applied, without explaining how the statute was satisfied, and by which Defendants.

Plaintiff's trial court response argued the requirements of the immunity statute, including due appointment, and that none of the Defendants had been duly appointed. Response Brief pp.

21-22, Apx. 23-24b. In a second bite at the apple, Defendants' filed a trial court reply brief which responded to the "due appointment" argument as follows:

> Plaintiff alleges that Defendants were not acting as a "duly appointed" peer review committee, and therefore cannot be afforded peer review immunity. On the contrary, Plaintiff himself alleges in his complaint at ¶52 that on or about August 18, 1998, the hospital president wrote to the chief of staff requesting a formal investigation into Plaintiff's conduct ¶54 he alleges that the Ad Hoc Committee was formed to investigate the allegations made by the hospital against Plaintiff. Formation of the committee was governed by medical staff bylaw 7.1-3, which read in pertinent part, **"[the Chief of] Service** shall immediately investigate the matter or appoint a special committee to investigate it." ... **Thus the Ad Hoc Committee was not an "inappropriate body" under the medical staff bylaws, but rather was "duly appointed" under the bylaws.**

Reply Brief pp. 3-4, Apx. 41-42b. (underscore in original brief, bold emphasis added).

Defendants expressly limited their trial court argument to the Ad Hoc Committee. They made no effort to suggest that the other individual defendants, the Hospital or the Medical Staff were duly appointed.

This pattern was repeated at the Court of Appeals. Plaintiff renewed his "due appointment" argument, clearly stating his position that each Defendant must separately qualify for immunity. Brief on Appeal, p. 34, Apx. 51b. Plaintiff again argued that none of the Defendants were "duly appointed" and that a separate immunity analysis (and hence due appointment analysis) was required for both the 1998 and the 2000 proceedings[13]. Plaintiff offered distinct due appointment arguments with respect to the Hospital (through its Board of Trustees), Hiltz, Miller, and the Ad Hoc Committee members. Moreover, although the Medical Staff Executive Committee is not named a Defendant, Plaintiff also argued that it was not a duly

[13] This latter point seems obvious, as in 2000 there was no ad hoc committee, Miller was no longer the Chief of Staff, and many of the Medical Staff committees were comprised of new members, in whole or in part.

appointed peer review committee either, and there was no immunity or privilege for communications to it by the Defendants[14]. Id.

In response Defendants repeated **verbatim** their one paragraph argument to the trial court – that the Ad Hoc Committee (and only the Ad Hoc Committee) was duly appointed. Response Brief, p. 23, Apx. 126a. A straight forward reading of Defendants' briefs clearly reveals the Court of Appeals was correct – Defendants confined their due appointment argument to the Ad Hoc Committee.

An argument Defendants *did* advance is that certain Defendants acted "in furtherance of" peer review. The legislature did not extend immunity to all those who claim to acting "in furtherance of" a review entity. Immunity is limited to the review entity, its duly appointed members, and those communicating to it. Thus, with the exception of the Ad Hoc Committee members, Defendants waived their immunity defense below by failing to present adequate argument.

2. The Ad Hoc Committee was not Duly Appointed

The Court of Appeals erred in its determination that the Ad Hoc Committee was duly appointed. In their argument below, Defendants admitted that Miller, who was then the Chief of Staff, appointed the members of the Ad Hoc Committee. However, Miller had no authority to appoint an ad hoc investigative committee. As cited by Defendants below, the relevant provisions of the Medical Staff By-Laws provide that the [Chief of] Service (i.e., the department

[14] Defendants confuse the status of the Executive Committee in this litigation when they claim the Court of Appeals erred with respect to "claims" against the Executive Committee. The Executive Committee is a committee of the Medical Staff, but is not itself a named defendant. As such, there are no "claims" against the Executive Committee *per se*. However, for communications to it to be privileged, or its actions immune, it must be a duly appointed peer review committee acting within a proper scope. When, as here, it sits in a disciplinary capacity, it is not engaged in peer review. See, Davis, *supra*.

chair), **not** the Chief of Staff, is authorized to investigate (or to appoint a committee to investigate) requests for corrective action. Medical Staff By-Law 7.1-3, Apx. 109a. Miller was not Plaintiff's Chief of Service[15], lacked authority to investigate, and no investigative committee appointed by him could be "duly appointed."

As extant in 1998, the Medical Staff by-laws required the Executive Committee to forward requests for corrective action to the appropriate Chief of Service for investigation at the departmental level. The Chief of Service was required to report the investigative results to the Executive Committee. Upon receipt of the investigative report, and after meeting with the affected physician, the Executive Committee would take action on the request for corrective action. Medical Staff By-Law 7.1-4, Apx. 109a.

In 1998 the Medical Staff By-Laws segregated the investigation from the adjudication. As Chief of Staff, Miller chaired the Executive Committee and headed the adjudication. It was inappropriate (and *ultra vires*) for Miller to hand pick the members of the Ad Hoc Committee. Plaintiff alleges that by choosing supportive cronies, Miller assured that no bona fide investigation would take place and that critical information would not be presented to the Executive Committee. Complaint §§51-56, Apx. 44a. This is precisely the type of mischief the immunity statute's "due appointment" requirement is intended to guard against. It is reasonable to assume that had the Chief of Service or a neutral bona fide committee conducted the investigation it would, at a minimum, have included notice to Plaintiff of the allegations against him and an opportunity to present his side of the story.

[15] Nor were any of the Defendants who served on the Ad Hoc Committee.

Notably absent in the record are the Medical Staff By-Law provisions governing peer review, which are in Defendants' control[16]. The excerpts appearing in the Defendants' Appendix were placed in the record by Plaintiff, in response to the motion for summary disposition. Defendants have never submitted the full by-laws for scrutiny. Article VII, the provisions submitted by Plaintiff, concern disciplinary proceedings (i.e., corrective action). The committees appointed under Article VII are disciplinary in nature. They are not formed for peer review purposes – other provisions of the by-laws govern the peer review committees. As Davis, *supra*, makes clear, disciplinary action is not peer review. Accordingly, even if the Ad Hoc Committee had been properly appointed, it was for the purpose of discipline, not peer review.]

3. None of the Other Defendants Was Duly Appointed

By the time of the 2000 disciplinary action, the Medical Staff By-Laws had been amended. Under amended Section 7.1-2 initial adjudication of requests for corrective action are handled at the departmental level. Only if the issue is not resolved at the department level to the satisfaction of the Chief of Service, Chief of Staff or the physician is it referred to the Executive Committee. Under amended Section 7.1-3, after such referral the full Executive Committee (no longer the Chief of Service) conducts an investigation. Medical Staff By-Laws Sections 7.1-2, 7.1-3, as amended, Apx. 119a-122a.

Plaintiff alleges that in 2000 this new procedure requiring attempted resolution at the departmental level was bypassed, at Hiltz' insistence. Complaint ¶90, 95, Apx. 48-49a. The Executive Committee acted prematurely. It did not yet have authority to act on any request for corrective action – it would gain such authority if, and only if, the matter were referred from the

[16] In the Long case, *infra*, plaintiff's failure to include by-laws was fatal to his contract claims. Here plaintiff attached available provisions and noted at oral argument that the full document is in Defendants' control. Summary Disposition Hearing transcript, pp. 38-39.

departmental review to the Executive Committee. Prior to that time it was not duly appointed to do so. Even then, as in 1998, the provisions invoked (and ignored) by Defendants concern only discipline, not peer review.

C. Plaintiff Sufficiently Alleges Malice

1. The Definition of Malice

The immunity statute does not define malice – it simply provides that immunity "does not apply to a person, organization, or entity that acts with malice." At the trial court Defendants argued that malice meant "the intentional doing of a wrongful act without just cause or excuse, with the intent to inflict an injury or under the law well (sic) imply an evil intent." Reply Brief p.3, Apx. 41b (citing Black's Law Dictionary 862 (5th ed. 1979). Defendants are barred from asserting a contrary standard on appeal[17].

At both the trial court and at the Court of Appeals, Plaintiff argued that a common-law malice was the appropriate definition in this case[18]. The trial court did not state which definition it employed, but one can infer it used a defamation definition as it employed a "clear and convincing" standard of proof sometimes discussed in defamation cases. The Court of Appeals, both the majority and Judge Murray in dissent, applied several additional standards.

The Court of Appeals had previously approved use of the defamation definition of malice in an appropriate context. In Veldhuis v. Allan, et al, 164 Mich. App. 131 (1987), the court stated

> We agree with defendant Davis Clinic that the definition of malice applicable in defamation actions also seems appropriate in the context of *MCL 331.531*; MSA 14.57(21). See *Regualos v Community Hospital, 140 Mich App 455, 463; 364 NW2d 723 (1985),* lv den *423 Mich 861 (1985),* citing *Lins v Evening News Ass'n, 129 Mich App 419; 342 NW2d 573 (1983).* Applying that definition, the statutory immunity does not apply only if the person supplying information or data does so with knowledge of its falsity or with reckless disregard of its truth or falsity. *129 Mich App 432.* Similarly, a

[17] Defendants inconsistency was pointed out at oral argument, and noted by Judge Murray
[18] See Plaintiff's Brief in Response pp. 16-19, Apx.18-21b, Plaintiff's Brief on Appeal pp. 39-45, Apx. 56-62b.

> review entity is not immune from liability if it acts with knowledge of the falsity, or with reckless disregard of the truth or falsity, of information or data which it communicates or upon which it acts.
>
> 164 Mich. App. at 136-137.

The Complaint meets this standard. However, this Court should consider other equally valid definitions of malice appropriate in this context. Neither the plain meaning of the statute nor Veldhuis restricts this Court from considering other definitions more appropriate in the a given set of facts.

The defamation standard may be appropriate when the alleged malice is limited to providing false information. However, it is noteworthy that the immunity statute was enacted in 1967, well before the courts decided the line of cases establishing a challenges definition of malice that would pass constitutional muster in the face of First Amendment challenges (these include the Lins case, cited by Regalos as noted in Veldhuis above).

More likely, the legislature intended to use malice in its common-law sense, using the plain-meaning of the word. Clearly, malice can be evidenced by many acts other than making or relying on false statements. One can easily imagine malicious action where malice is not dependant on the falsity of information. For instance, malice can present where material information is intentionally withheld, such that the statements which are made are misleading, if not *per se* false.

Likewise, a peer review entity could act with actual malice based on true information by using that information as a pretextual basis for disciplinary action it did not in good faith believe was necessary, or in imposing an unreasonable or unwarranted level of discipline – such as terminating privileges for a minor procedural violation of hospital rules.

2. Discrimination is a Malicious Act

Finally, as both the majority and the dissent held below, discrimination is an act of malice. The majority reached this result by defining malice as "that state of mind which is reckless of law and of the legal rights of the citizen." Judge Murray in dissent reached the same conclusion regarding discrimination but applied both a defamation standard (in discussing the bad faith referral to the HPRP) and yet another definition of malice: "the intent, without justification or excuse, to commit a wrongful act." As Judge Murray noted, Defendants also conceded at oral argument that discrimination claims may fall within the definition of malice.

The difficulty with relying on a defamation standard to find malice in discrimination is that it requires a false statement. Yet the worst type of discrimination involves no false statements at all. Consider a peer review committee that made written findings that "African-Americans should not be granted staff privileges" or that "Women should not be granted emergency room privileges." In these "smoking gun" intentional discrimination examples there are no false statements; ignorant statements, boneheaded statements, but no false statements. The writers honestly reveal their discriminatory intent. The defamation standard urged by Defendants and *amicus* Michigan Health & Hospital Association would shield this type of intentional discrimination in immunity.

3. The Other Allegations of Malice

Whichever standard is used, the complaint sufficiently alleges facts demonstrating malice[19]. Defendants' actions evidence not only extreme ill will, but statements that were known to be false or that were so misleading in their omissions that they became so. The allegations, if

[19] Should the Court disagree, Plaintiff requests, as he did below, remand with leave to amend to comport to whatever standard of malice the Court may establish.

assumed true, are clear and convincing evidence of malice that would support a jury finding of malice.

It should be noted that malice is not a *prima facia* element of any of the claims asserted by Plaintiff. Accordingly, Plaintiff contends that he is not required to allege malice in his complaint. Rather, absence of malice is an element of the affirmative defense of immunity, and the burden is on Defendants to plead and prove their peer review immunity defense. See Ironside v. Simi Valley Hospital, 103 F.3d 482, 484 (6th Cir. 1996).

Assuming, *arguendo*, that it is Plaintiff's burden to prove malice, it remains Defendants' burden to plead and prove their affirmative defense of immunity. Under notice pleading rules, plaintiffs should not be required to allege facts to defeat an affirmative defense before it is raised. Should the Court disagree, there are sufficient factual allegations in the complaint from which malice may be inferred, as well as a specific allegation of malice. Complaint at ¶147[20].

Perhaps no allegation of malice is more significant that the allegation that none of the Defendants believed Plaintiff was or might be impaired, and that the referral to HPRP was in bad faith. A bad faith referral was an extreme act of ill-will.

Though the Court must assume the HPRP allegation is true, Plaintiff does not rely merely on a conclusory allegation. The complaint alleges many facts from which bad faith can be inferred. The common sense nature of Orders A-D and Plaintiff's long history of writing them, with acquiescence from Hospital administrators, reveals that Orders A-D were not, in themselves, evidence of any mental impairment. The patient noncompliance issue is not an

[20] This is Plaintiffs only allegation of containing the word "malice" and concerns the HPRP referral. The Complaint alleges numerous facts from which malice may be inferred. Should the Court disagree with this Plaintiff's assessment of the pleading burden, and require use of the word "malice," the appropriate step would again be remand with leave to amend.

irrational concern – as evidenced by medical literature on the subject and indeed the Hospital's willingness to suggest a pharmacy consult procedure to deal with noncompliance.

Nor was their anything suggesting impairment in how Plaintiff handled the issue. Over years he met with administrators and nurses to discuss his concerns. When asked to alter course and work with committees he did so. Only when Hospital administrators refused to resolve the issue did Plaintiff begin writing Orders A-D. His determination may be seen as noble, caring, stubborn or even politically naïve. It cannot be seen as impairment. Surely it must take something more than disagreeing with a hospital administrator to raise a reasonable belief that a physician is impaired.

The underlying theme in the complaint is that Hiltz was engaged in a "power struggle," strongly suggesting ill will towards Plaintiff. This is not Plaintiff's characterization of Hiltz's motivations; this is how Miller himself described it. Complaint at ¶51. Defendants' power struggle motivated them to resort to discipline to subdue Plaintiff and silence the debate over the patient care issue. Subverting the disciplinary process to achieve this end was a malicious act – improperly motivated by political considerations. This is exactly the type of malicious behavior that the legislature exempted from peer review immunity.

The allegations about how each of the disciplinary actions was conducted show ill-will towards Plaintiff. Defendants demonstrated their ill will by failing to provide notice of charges, refusing to hear Plaintiff's response, and violating the by-laws to deny Plaintiff's due process rights. Hiltz's repeated refusal in 1995-1998 to respond to the concerns of Plaintiff and medical staff committees on the patient care issue demonstrated his growing contempt for Plaintiff.

Moreover, Hiltz and Miller withheld vital information from decision makers, particularly the fact that Hospital administration (via the Vice President) had approached Plaintiff with an alternative solution to the patient care issue (e.g., the pharmacy consult). Plaintiff had cooperated

and agreed with this suggestion. To withhold this fact from the Ad Hoc Committee, the Executive Committee and the Hospital Board was a material omission of fact. Omitting this critical development permitted Defendants to portray Plaintiff as unreasonable and disruptive, and to negate Plaintiff's contention that he was concerned only about patient care.

The 2000 disciplinary action again demonstrates malice. The patient care issue was a contrived pretext for discipline. The Court should recall the allegations – Plaintiff had given appropriate orders for a patient's care, and given Orders A-D, and remained on site at the Hospital. For unexplained reasons, someone authorized a nurse to call in the Head Nurse and the Chief of Staff, after hours, to intervene in the patient's care. Discovery in this case will reveal more about what transpired, but the permissible inference from the complaint is that a patient care issue was fabricated in order to discipline Plaintiff, who had recently resumed writing Orders A-D after Hospital administrators curtailed the pharmacy consult. Interfering in a physician-patient relationship to create a pretext for discipline is malicious.

Hiltz's rushed but failed attempt to secure Plaintiff's summary suspension in 2000 shows how eager he was to snare Plaintiff. When the Executive Committee, under new leadership, would not play along, outside counsel was brought in to pressure action. Counsel would not give the opinion the Executive Committee sought – were Plaintiff's orders unlawful, or was the Hospital's refusing to permit them the unlawful act? Instead of responding to legitimate concerns, Plaintiff's due process rights were again trampled, and he was forced to appear without counsel in a highly adversarial proceeding.

The discipline imposed in 2000, lifetime probation, was extreme and disproportionate. It reveals the malice and ill-will behind Defendants' actions. They sought to silence Plaintiff in 1998; by 2000 their motives had expanded to include retaliation for Plaintiff threatening to assert his civil rights.

III

THE COURT OF APPEALS CORRECTLY APPLIED THE DOCTRINE OF JUDICIAL NONREVIEW BY LIMITING IT TO ITS HISTORICAL PURPOSES

A. The Judicial Nonreview Doctrine

Prior to 2005, Michigan courts generally applied an overbroad interpretation of the doctrine that medical staffing decisions were not reviewable. This Court has never ruled on the merits or limits of the doctrine.

1. Development of the Doctrine

The doctrine was first adopted by the Court of Appeals in Hoffman v. Garden City Hospital - Osteopathic, 115 Mich. App. 773 (1982). There two physicians applied for staff privileges at defendant hospital and were denied privileges based on lack of need. They brought suit and after proofs were entered, the trial court granted a motion for involuntary dismissal. On appeal the Hoffman court declined to review the reasons for the denials, citing at 1963 federal district court ruling as follows:

> The action of hospital authorities in refusing to appoint a physician or surgeon to its medical staff, or declining to renew an appointment that has expired, or excluding any physician or surgeon from practicing [sic] in the hospital, is not subject to judicial review.

Hoffman at 778-779. (citing Shulman v. Washington Hospital Center, 222 F. Supp 59 (DC 1963)).

In Hoffman, and every reported Michigan case following, the doctrine has been applied only in instances where staff privileges have been denied or terminated, with the result that the affected physician is no longer providing (or never permitted to provide) patient care.

The doctrine had never been applied in cases alleging a violation of public policy, particularly as evidenced by a state or federal statute. Thus, in Hoffman, the court considered the merits of plaintiffs' restraint of trade claims. Hoffman at 779-780.

Several termination/denial of staff privilege cases followed in the mid-1980s, and the Court of Appeals applied an ever expanding interpretation of the doctrine. *See*, Regualos v Community Hosp., 140 Mich App 455 (1985); Dutka v. Sinai Hospital, 143 Mich App 170 (1985); and Bhogaonker v. Metropolitan Hospital, 164 Mich. App. 563 (1987).

The doctrine has never been interpreted as an absolute bar to judicial review. In Sarin v. Samaritan Health Center, 176 Mich App. 790 (1989) the Court made clear that under appropriate circumstances, judicial review was proper. The Sarin court stated:

> While there may be some situations where a court should be able to consider a hospital's action without violating the principle of nonreviewability, this case is not of that sort.

176 Mich. App. at 795.

Sarin was a staff privilege termination case. Although it clearly left the door open for judicial review, the Sarin court did not articulate what facts or circumstance would warrant such review.

The Court of Appeals articulated potential exceptions to the doctrine in Long v. Chelsea Community Hospital, 219 Mich. App. 578 (1996). There the court followed Hoffman and Sarin, but with this caveat:

> The above law is limited to disputes that are contractual in nature. We decline to articulate a broad principle that a private hospital's staffing decisions may *never* be judicially reviewed. Indeed, in doing so, we reiterate the proposition from *Sarin* that, under some circumstances, a court may consider a hospital's decisions without violating the nonreviewability principle. *Sarin, supra at 795.* **Private hospitals do not have carte blanche to violate the public policy of our state** as contained in its laws.
>
> 219 Mich. App. at 586, 587 (emphasis added).

The Long court noted that even in prior cases applying the doctrine, courts had considered claims based on a violation of public policy. The Long court observed that Hoffman had reviewed the restraint of trade claim. Likewise, in Muzquiz v. W.A. Foote Mem. Hospital, 70 F.3d 422,430 (6th Cir 1995), the Sixth Circuit had reviewed state and federal discrimination claims. Long, supra, at 587-588.

The Long plaintiff argued that his case fell within Sarin's exception. The Long court did not articulate the plaintiff's argument, but rather concluded that because the pertinent hospital by-laws were not in the record, it could not review the merits of a by-law based argument attempting to fit within the Sarin exception. Id. at 588. Far from being a flat rule against review, the Long court suggests the Sarin exception remained, and a plaintiff need only present appropriate facts to obtain review.

Long was the last published Court of Appeals decision applying the doctrine. As of that 1996 decision the doctrine permitted review of public policy violations (such as antitrust and discrimination) and also permitted review of other claims under as yet undefined standards.

2. Retreat from the Doctrine

As the majority below noted, there was substantial jurisprudential drift following Hoffman. The opinions moved beyond the original purpose and rational underlying the doctrine, and created inconsistent results and overbroad statements of the doctrine's reach. For instance, some courts began opining that Michigan courts lacked subject matter jurisdiction to hear medical staffing cases.

The Court of Appeals began its retreat from the doctrine in Derderian v Genysis Health Systems, 263 Mich App 364; 689 NW2d 145 (2005), (appl. for lv. denied ____ Mich ____ (2005)). There the trial court had dismissed a medical staffing claim on the basis that the non-review doctrine meant Michigan courts lacked subject matter jurisdiction. Reviewing Hoffman and its progeny, the Derderian court concluded that earlier courts holding that the doctrine

removed subject matter jurisdiction were incorrect. It based its conclusion on general considerations of jurisdiction and on analysis of the historical origins of the doctrine:

> We also find support for our conclusion in the judicial nonintervention doctrine itself. The earliest Michigan cases discussing the doctrine do not characterize it as one depriving the court of subject-matter jurisdiction. Rather, these cases merely state that the staffing decisions of private hospitals are not subject to judicial review. *Hoffman v Garden City Hosp-Osteopathic*, 115 Mich App 773, 778-779; 321 NW2d 810 (1982);*Regualos v Community Hosp*, 140 Mich App 455, 461; 364 NW2d 723 (1985). **This doctrine does not arise from a limitation on the court's authority, but, in part, from the distinction between public and private hospitals.** In *Hoffman*, for example, the Court acknowledged that precedent required public hospitals to afford due process to physicians, *Milford v People's Community Hosp Auth*, 380 Mich 49; 155 NW2d 835 (1968); *Touchton v River Dist Community Hosp*, 76 Mich App 251; 256 NW2d 455 (1977), but recognized and chose to follow the majority position that private hospitals, on the other hand, have "the power to appoint and remove [staff] members at will without judicial intervention." *Hoffman, supra* at 778. Since *Hoffman*, this Court has refrained from reviewing numerous claims, framed in various ways, that implicate the hospital's decision and the basis for its decision, see, e.g., *Sarin v Samaritan Health Ctr*, 176 Mich App 790, 794; 440 NW2d 80 (1989);*Veldhuis v Central Michigan Community Hosp*, 142 Mich App 243, 247; 369 NW2d 478 (1985), **while "declin[ing] to articulate a broad principle that a private hospital's staffing decisions may *never* be judicially reviewed,"** *Long v Chelsea Community Hosp*, 219 Mich App 578, 586; 557 NW2d 157 (1996). **Accordingly, because this doctrine, at its core, is not a limitation on the court's authority,** we conclude that its application does not deprive the court of subject-matter jurisdiction. [5]
>
> **Having reached this conclusion, we may address the trial court's decision that plaintiffs' claims fail as a matter of law.**

Id. 376-377 (emphasis added).

The Derderian court clearly began the Court of Appeal's reconsideration of the doctrine. It noted that the doctrine arose not from limitations on the courts' authority, but from the distinctions between public and private hospitals. The Derderian court then proceeded to review the merits of the plaintiff's tort and contract claims, including fraud, promissory estoppel, tortuous interference, whistleblower retaliation, and invasion of privacy.

3. The Feyz Decision

The Court of Appeals' decision in this case followed Derderian. The majority continued the Derderian court's analysis of jurisprudential drift that was plaguing the doctrine. In a thorough and well reasoned opinion, the majority looked at the underpinnings of the doctrine which revealed that appropriate application of the doctrine was far more limited. The majority carefully analyzed the cases relied on by Hoffman and leading opinions from other jurisdictions. Its detailed case analysis, not repeated here, led the majority to a series of conclusions about the doctrine and its evolution:

> The doctrine that staffing decisions at private hospitals are not subject to judicial review has its roots in Michigan jurisprudence in [*Hoffman*]..., concluding that "the decisions of the governing bodies of private hospitals are not subject to judicial review." *Hoffman, supra* at 778. A review of this principle, however, reveals that there is not a sweeping judicial abstinence from reviewing decisions of private hospitals as suggested by some of the more recent cases and by the trial court in the case at bar. Rather, it is the much more limited proposition that private hospitals are not subject to the same review that would be given a public hospital. That is, a private hospital is a private employer, not a public employer, and should be treated like a private employer. Therefore, while a private hospital is not subject to the same scrutiny as a public employer in terms of whether the constitutional rights of its employees were violated, the doctrine does not create any greater insulation from scrutiny than that enjoyed by any other private employer.
> ...
>
> We do see in *Hoffman* the sweeping statement that "the decisions of the governing bodies of private hospitals are not subject to judicial review." *Id.* at 778. But, if we **look** at the underpinnings of these decisions, we see that the principle is not quite so sweeping after all.
>
> ...
> The failure in *Long*, like *Sarin* and other cases, is that it does not examine the roots of the principle of nonreviewability and discover that a breach of the bylaws is recognized as an exception to the principle. Moreover, while *Long* accepts the concept that the principle applies to breach of contract claims, it overlooks the origins of the doctrine and that the doctrine was not intended to apply to contract claims. Thus, when the plaintiff in *Long* argued that "his claim is not a constitutional due process argument, but rather is based on a breach of defendants' bylaws, and thus this Court should review it," *id.*, the plaintiff was exactly correct

when the principle is viewed in its original incarnation.

...

> In sum, while some of the decisions of this Court have drifted from the formulation of the nonreviewability doctrine, that doctrine, when viewed in historical perspective, stands for the modest proposition that a private hospital is subject only to the legal obligations of a private entity, not to the greater scrutiny of a public institution. It is subject to the same potential civil liability of any private corporation that violates an employment statute, breaches a contract, or the like.

Opinion pp.6-14, Apx 15-23a.

B. Defendants Misstate the Majority's Approach to Stare Decisis

Defendants make no direct challenge to the majority's thoughtful analysis of Hoffman, Shulman, or the other cases underlying the doctrine. Defendants do not contend the majority misread the historical cases. Instead, they focus on *stare decisis* and on the questionable notion from Shulman that courts are unqualified to evaluate medical staffing disputes.

In a two page single spaced footnote, Defendants cite a litany of unreported and reported cases applying the doctrine. Of these only one, the Long case, was decided after November 1, 1990, implicating MCR 7.215(J)(1). This Court, of course, is not bound by any decision of the Court of Appeals. As discussed, infra, the majority opinion should be affirmed for its sound reasoning and important policy considerations, but Defendants' intemperate attack on the Court of Appeals majority warrants response.

The majority below did not ignore MCR 7.215(J)(1). Rather, it looked closely at Long to discern its precedential effect:

> In terms of Michigan law, only the *Long* decision is precedentially binding. And that decision is clear on the point that private hospitals are subject to the various civil rights acts. Accordingly, the trial court improperly dismissed counts I through IV of plaintiff's complaint on the basis of the nonreviewability doctrine as that doctrine does not apply to alleged statutory violations.

> With respect to count V (invasion of privacy), the *Long* decision is silent on the issue of tort liability of private hospitals. Accordingly, we are free to remain true to the original scope of the nonreviewability doctrine and conclude, as did the Court in *Alfredson*, that private hospitals are capable of committing torts and, when they do, are as subject to be held liable as any other private corporation. Accordingly, we conclude that summary disposition was improperly granted on the basis of the nonreviewability doctrine on this count as well.
>
> Turning to count VI (breach of fiduciary and public duties), this count seems to be related to the heart of what the nonreviewability doctrine was designed to address—claims that hold private hospitals to a higher standard than other private corporations, seeking to impose a public duty akin to public hospitals. Accordingly, we conclude that the trial court did correctly apply the nonreviewability doctrine to this count.
>
> Finally, as for count VII (breach of contract based on a violation of hospital bylaws), it is unclear whether *Long* would control. *Long* did not directly address this issue, concluding that the breach of bylaws claim was not adequately pleaded. But the *Long* Court did state that a breach of contract or breach of bylaws claim is potentially viable if it does not violate the nonreviewability doctrine. As discussed above, in our view, breach of contract and breach of bylaws claims do not violate the doctrine unless they seek to impose greater liability on a private hospital than what another private employer would be subject to under the law.

Opinion pp. 14-15, Apx. 23-24a

The majority did not violate MCR 7.215(J)(1). It analyzed Long, confronted some of the uncertainty in the Long decision, and ruled logically and in good faith. It is worth noting that the majority's approach is consistent with Derderian, *supra*, a decision this Court let stand.

C. The Doctrine Should be Limited to its Historical Limits

The majority was thorough in its case analysis of the nonreviewability doctrine. Because it was returning to historic roots, perhaps the majority saw less need to articulate the important policy reasons that favor judicial review. There are many.

The Court should take judicial notice of the substantial changes in the legal and medical climates since Shulman. The business of the courts and of hospitals is not what it was in 1963. Physicians toil in a very different environment, and courts are called on every day to resolve medico-legal disputes. Consider this passage from Shulman:

> There are sound reasons that lead the courts not to interfere in these matters. Judicial tribunals are not equipped to review the action of hospital authorities in selecting or refusing to appoint members of medical staffs, declining to renew appointments previously made, or excluding physicians or surgeons from hospital facilities. **The authorities of a hospital necessarily and naturally endeavor to their utmost to serve in the best possible manner the sick and the afflicted who knock at their door**. Not all professional men, be they physicians, lawyers, or members of other professions, are of identical ability, competence, or experience, or of equal reliability, character, and standards of ethics. The mere fact that a person is admitted or licensed to practice his profession does not justify any inference beyond the conclusion that he has met the minimum requirements and possesses the minimum qualifications for that purpose. **Necessarily hospitals endeavor to secure the most competent and experienced staff for their patients. Without regard to the absence of any legal liability, the hospital in admitting a physician or surgeon to its facilities extends a moral imprimatur to him in the eyes of the public.** Moreover not all professional men have a personality that enables them to work in harmony with others, and to inspire confidence in their fellows and in patients. These factors are of importance and here, too, there is room for selection. In matters such as these the courts are not in a position to substitute their judgment for that of professional groups.

Shulman, supra at 64 (emphasis added).

However apt this reasoning was in 1963, the Shulman court's deference to the culture of professional men and the natural tendencies of hospitals seems out of step with current realities. The practice of medicine has evolved tremendously in the last 45 years. Large hospital conglomerates, the ascension of hospital administrators, anti-competitive behavior, the emergence of managed care and alternative practice structures, and the economic pressures of rising costs have combined to make the modern hospital a very different creature than the noble and revered institution observed by the Shulman court.

Courts, too, are different. The rise in employment litigation has thrust courts further into employment disputes in a society that, since 1963, is increasingly educated, service oriented, and professional. Every day the courts are called upon to resolve disputes concerning the professional competence of parties engaged in a wide array of professions: architecture, engineering, computer science, accountancy and on and on. In many respects courts (and juries) are no more

qualified to evaluate these professions than they are medicine, and yet they perform that role admirably.

In the case of medicine, it is significant that courts routinely evaluate the professional competence of physicians in malpractice cases, at a frequency unheard of in 1963. Civil rights statutes enacted after Shulman apply to hospitals, and even under Long Michigan courts will hear a physician's civil rights claims[21]. In doing so they necessarily must consider the issues of competence and performance the Shulman court sought to avoid. The same holds true when an aggrieved physician brings an antitrust case. One must wonder why, in a mixed case like this one, the trial court is competent to evaluate a physician's performance in deciding the civil rights claims, but is not competent to evaluate the very same evidence and determine if a contract was breached or a tort committed.

In short, Michigan courts are already called upon to make the type of evaluations the doctrine seeks to avoid. It seems the doctrine has outlived its utility, and reinstating it would be ill-advised. Reinstating the doctrine would return Michigan to the extremely small minority of jurisdictions that do not permit judicial review. Defendants concede the majority rule is opposite. As noted by the majority below, the better view is to allow medical staffing claims to proceed.

[21] One may pause here to consider the status of minorities and women in the medical profession in 1963, prior to the passage of key civil right legislation, and how they fared as Eisenhower-era hospitals "endeavored to secure the most competent and experienced staff for their patients."

D. Michigan's Peer Review Confidentiality Provisions Favor Limited Application of the Doctrine

Defendants offer for the first time a novel theory that the peer review confidentiality provisions "compel" reinstatement of the nonreviewability doctrine. No such argument was stated at the Court of Appeals, and issues raised for the first time on appeal are not ordinarily subject to review. Booth v University of Michigan, 444 Mich 21 (1993).

If anything, the confidentially provisions, like the immunity statute, indicate the legislature contemplated that courts *would* review medical staffing decisions. The legislative granted limited, not absolute, immunity. Acts of malice or beyond the scope of peer review receive no immunity or privilege. Absent immunity, one should presume the legislature envisioned litigation might arise. Nonreviewability is inconsistent with this legislative scheme.

Moreover, the parade of horribles suggested by Defendants ignores the fact that federal courts already hear discrimination and antitrust claims, and do not recognize state privileges, even when state law claims are coupled with federal claims. See, e.g., Vermani v Novant Health Inc., 259 F.3d 284 (4th cir. 2002). At the time they participate in peer review, participants have no way of knowing if an aggrieved physician will bring a claim in federal or state court[22]. The confidentially provisions are in many ways illusory, and any alleged chilling effect is (or should be) already factored into the calculus of peer review participation.

Defendants sidestep this blunt reality with a footnote asserting that "These concerns often do not apply in federal courts which may not apply Michigan statutory confidentiality or evidentiary privilege limitations to federal claims." Appellants' Brief fn. 2, p.30. This is doublespeak. The "concern" is for candid assessments during peer review at the hospital, not months later in a courtroom.

[22] At least, that is, when the aggrieve physician is a member of a protected class or an economic competitor capable of asserting an antitrust claim. Plaintiff suggests the majority of physicians qualify as potential litigants.

E. Assuming, *arguendo*, this Court Reinstates an Expanded Doctrine of Nonrewability, Plaintiff has Alleged Facts Warranting Review

Even under the doctrine as contemplated by the Long court, Hospitals do not have *carte blanche* and review it available if the circumstances or public policy warrant. There are several grounds for permitting review here, even under an expanded reading of the doctrine.

First, this is a textbook case of a Hospital taking *carte blanche.* The gross irregularities and malicious actions alleged here should give the Court pause. The allegations here reveal how far Hospitals will go when protect by a doctrine that assures no judicial review of their actions, and the how the doctrine is interpreted by the health car bar. Even when physicians attempt to question ill-conceived actions, hospital counsel is there to assure them that under the doctrine these cases will be dismissed. Complaint

The Court could also adopt an interests-based test, an appropriate refinement if the Long approach were reinstated. In cases that have permitted review of discrimination and antitrust claims, it is not merely the existence of a statutory cause of action that permits review. Rather it is the public interest the statute serves. By focusing on the source of the cause of action, and not the underlying public policy, some courts have reached the conclusion that certain types of claims are not reviewable. The unfortunate result is that some courts have ignored the substance of Long, and suggested that only statutorily conferred claims are reviewable.

In appropriate circumstances, breach of contract or other common law claims should be reviewable if the public interest is affected. The doctrine of non-reviewability has only been applied in circumstances where a hospital denied or revoked privileges. When the physician brings suit, the interest being served in the physician's private economic interest in maintaining staff privileges at a particular hospital. Reviewing medical competence is not without risk, especially if private economics motivate the plaintiff.

No such risk is present in this case. Plaintiff is and remains fully credentialed by the Hospital. He treats patients and has done so continuously. He is eligible to perform and does perform the same procedures he always has. He has never faced a malpractice claim, and his clinical treatment of patients has not been questioned. This Court is not being asked to second guess Plaintiff's medical qualifications, and by retaining Plaintiff on staff it is clear that the Defendants do not challenge his competence either.

Instead, what this Court is being asked to review is an abuse of power -- a violation of Plaintiff's basic rights to fairness and due process afforded him by the medical staff by-laws. Plaintiff's actions to improve patient care were a matter of public interest. More importantly, there is a key public interest in preserving the autonomy and independence of physicians in matters of patient care, a public interest that warrants exception to the Long approach.

IV

MCL 333.1624 PROVIDES DEFENDANTS NO IMMUNITY FOR THEIR BAD FAITH REFERRAL TO THE HEALTH PROFESSIONAL RECOVERY PROGRAM

Defendants HPRP argument is based on a gross misreading of Plaintiff's discrimination claims. Defendants' attempt to characterize Plaintiff's civil rights claims as stemming from a single act – the Medical Staff Executive Committee's referral of Plaintiff to HPRP and the resulting mandatory (and unnecessary) psychiatric examination that followed.

Defendants seize on language in the majority opinion that, for purposes of Count V only (invasion of privacy), there was no allegation of malice with respect to the HPRP referral. Opinion p. 5, Apx. 14a. Defendants attempt to bootstrap that language into an argument that if there was no malice involved with the HPRP referral, there can be no malice as to *any* of Plaintiff's civil rights claims because all such claims derive from a single event – the HPRP referral.

As Judge Murray acknowledged, Plaintiff's discrimination and civil rights claims are much broader than the HPRP referral. Defendants mischaracterized the Complaint by asserting that Plaintiff's claims are for "regarding him as disabled." Regarding Plaintiff as having a disability is not in itself a claim, it is merely one of three methods by which Plaintiff can qualify as an "individual with a disability" under the relevant civil rights statutes. For some of his claims that isn't even necessary, as the statutes prohibit unlawful medical testing of and retaliation against all persons, not just individuals with disabilities.

What is actionable, and what Plaintiff alleges, are multiple discriminatory acts committed by the Defendants. Yes, these include requiring him to undergo an unnecessary psychiatric examination and taking disciplinary actions on the basis of that referral, but there are many other acts complained of, including, *inter alia*, disproportionate discipline, and retaliation for asserting his rights under the relevant civil rights statutes. Even if Defendants were correct that the HPRP statutes provide immunity for the referral to the psychiatrist, Plaintiff's other claims of discrimination would survive.

Plaintiff believes the majority erred in its suggestion that the Complaint contains no allegation of malice with respect to the Executive Committee's referral of Plaintiff to HPRP. Opinion p.5, Apx. As a practical matter, this language is *dicta* and unnecessary. The Court of Appeals ruled that only the Ad Hoc Committee could be considered a duly appointed peer review committee. The Executive Committee is *not* a duly appointed peer review committee and therefore its actions cannot give rise to immunity. Accordingly, it is irrelevant for immunity purposes whether it acted with malice because it is not a peer review entity for purposes of this case.

As Judge Murray noted, the Complaint alleges that Defendants referred Plaintiff to HPRP with full knowledge that he had no mental or physical limitations. The specific allegations are at

¶57 (the Executive Committee referred Plaintiff to the HPRP) and at ¶60 (none of the Defendants held a good faith belief that Plaintiff was or might be impaired). Note that there is no allegation that the Ad Hoc Committee referred Plaintiff to HPRP or recommended a referral.

Referring Plaintiff to HPRP without a good faith belief that Plaintiff was or might be impaired was a malicious act under any of the definitions of malice used by the Court of Appeals. As Judge Murray explained, referral under such circumstances would satisfy the Regualos defamation standard. Such a referral would also evidence "the intent, without justification or excuse, to commit a wrongful act," Judge Murray's alternate definition of malice.

Likewise, the Complaint alleges malice under the majority's view that a violation of a civil rights act is a malicious act. Each of three civil rights act in this action contain prohibitions with respect to medical examinations. If, as Plaintiff alleges, the psychiatric examination and/or the board's actions in reliance on the examination violate the civil rights laws, then malice is alleged under the standard announce by the majority below – a violation of a civil rights act is a malicious act. Accordingly, it was error to rule that no allegation of malice had been made with respect to the Executive Committee's referral of Plaintiff to HPRP.

Whether the Defendants acted with malice in making the HPRP referral will be determined after discovery on remand. At this point in the proceeding, Plaintiff is unsure who, specifically, recommended he be referred. For this reason, Plaintiff was careful in pleading about the referral. At ¶57 Plaintiff alleges that the Ad Hoc Committee issued a letter on September 21, 1998, after its investigation. Plaintiff alleges the Executive Committee took action the next day, in part on the basis of the Ad Hoc Committee's letter. Plaintiff further alleges the Executive Committee (not the Ad Hoc Committee) referred him to HPRP.

Plaintiff makes no allegation that the Ad Hoc Committee recommended a HPRP referral or expressed any concern that Plaintiff might be impaired. There is no allegation that the HPRP

referral was based on anything suggested by the Ad Hoc committee. The Executive Committee took other actions in addition to the HPRP referral, such as issuing warnings. It's possible that those actions were consistent with the report of the Ad Hoc Committee, but that the HPRP referral was not.

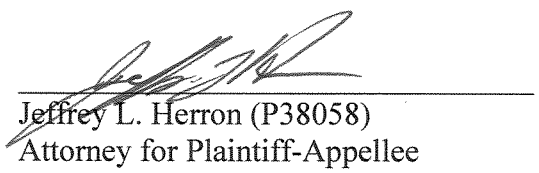
RELIEF REQUESTED

Plaintiff-Appellee Bruce B. Feyz, M.D., respectfully request that this Honorable Court affirm the Court of Appeals, with the exception of (1) its apparent finding that the Complaint contains no allegation of malice with respect to Defendants' referral of Plaintiff to the Health Professional Recovery Program, and (2) findings that those Defendants serving on the Ad Hoc Committee were duly appointed to a peer review committee within the meaning of MCL 331.531.

Should this Court determine to reinstate a broader doctrine of judicial nonreviewability of medical staffing decisions, Plaintiff requests this Court find that Plaintiff's civil rights claims are reviewable as a matter of law, and that the Complaint alleges facts warranting judicial review of Plaintiff's contract and tort claims in this action.

March 16, 2006

Respectfully submitted.



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